Highlights of the HMA Council Meeting of January 10, 1992

Members present at the meeting were: S Wallach, J Chang, A Don, J Spangler, J McDonnell, C Kam, R Stodd, L Howard, M Joshi, R Lee-Ching, R Adaniya, P Blanchette, HH Chun, R Embry, J Kim, R Kimura, S Brady, HKW Chinn, H Fong, M Shirasu, C Kadooka, R Goodale, J Betwee, H Percy, T Smith, G Goto, J Lumeng, W Chang, N Winn, A Kunimoto, M Bainum; J Gaspar - Medical Student Representative; F Reppun - HMJ Editor; J Armstrong - Resident Physician Representative - Tripler AMC; V Woo - Legal Counsel, and special guest B Fong - Medical Director-AETNA. Also present was Rosie Villagomez - President of the Medical Student Section. HMA staff present: J Won, B Kendro, N Jones, P Kawamoto, J Asato, J Estioko, L Tong, and M Lindsey- recording secretary.

The Council supported the Tobacco Coalition to conduct a public opinion poll regarding smoking in the workplace and approved $500 as requested.

Access to medical care has become a major issue. The Council approved a *pro bono* form and authorized a survey of physicians who have provided continued care for indigent patients despite personal sacrifice.

The Council adopted the report of the AIDS Subcommittee. Those interested in reviewing it may do so at the HMA office. It is too lengthy and too specific to be included here.

The Council agreed to have a monthly insert: "Health Update," in *Hawaii Family;* it will be overseen by the PR Committee and at no cost to HMA.

The Council supported the concept of creating a chapter of Doctors Ought to Care (DOC) with its primary goal being the education of the community regarding the hazards to health of tobacco smoking.

The Council approved the Ilikai Hotel as the site of the 1992 HMA Annual Meeting in Honolulu on October 9-11, and for the 1993 HMA Annual Meeting to be held at the Intercontinental Resort at Wailea, Maui, on October 8-10, 1993.

The Council approved the Legislative Committee recommendations:

a) to support the proposed bill to extend the needle/syringe exchange program;

b) to support the proposed bill to create a special medical license for educational and teaching purposes;

c) *not* to support the bill to revise Section 455, HRS, to allow a naturopathic physician to be licensed in the State of Hawaii without examination if the person holds a valid license in another jurisdiction; and

d) *not* to support a revision of Section 455-1, HRS, that would expand the scope of practice by naturopathic physicians to include prescribing or dispensing of prescription drugs.

Bernard Fong, Medical Director at Aetna-Medicare and HMA President Stephen Wallach presented the changes in 1992 in the Medicare program.

Andrew Don MD
Secretary

Prescriptive privilege by permit

It was somewhat unfortunate that the HMA House of Delegates, last October at the 135th Annual Meeting on Kauai, turned back for further review the pressing issue of Prescriptive Powers for Nurse Practitioners. We call the action unfortunate because the issue is likely to be decided in the 1992 session of the Hawaii State Legislature. The makers of laws in our state are faced with the difficulty of deciding, as lay people, an issue that has the health care profession divided and polarized.

Ernest Bade and Janice Friend, representing the HMA Nurses Prescribing Ad Hoc Committee, presented Resolution No 6 to the House.

Knowing that this resolution would generate a lengthy discussion, particularly since it had been recommended a "no" vote by the Reference Committee on Finance and Miscellaneous Business, the Speakers had arranged for it to be considered by the House toward the end of the last day's agenda. Their intentions were honorable; otherwise, the entire agenda might have been stalled.

In retrospect, that was the first of the unfortunate happenings. True, the sessions ended and the meeting was adjourned at a reasonable hour. However, as has happened too often at these HMA annual meetings, particularly when held on an island other than Oahu, many delegates have to leave prior to

(Continued) ➤

ONCE DAILY **180 mg**

Calan® SR

verapamil HCl 180 mg

SUSTAINED-RELEASE CAPLETS

The recommended starting dose for Calan SR is 180 mg once daily. Dose titration will be required in some patients to achieve blood pressure control.

A lower initial starting dosage of 120 mg/day may be warranted in some patients (eg, the elderly, patients of small stature).

Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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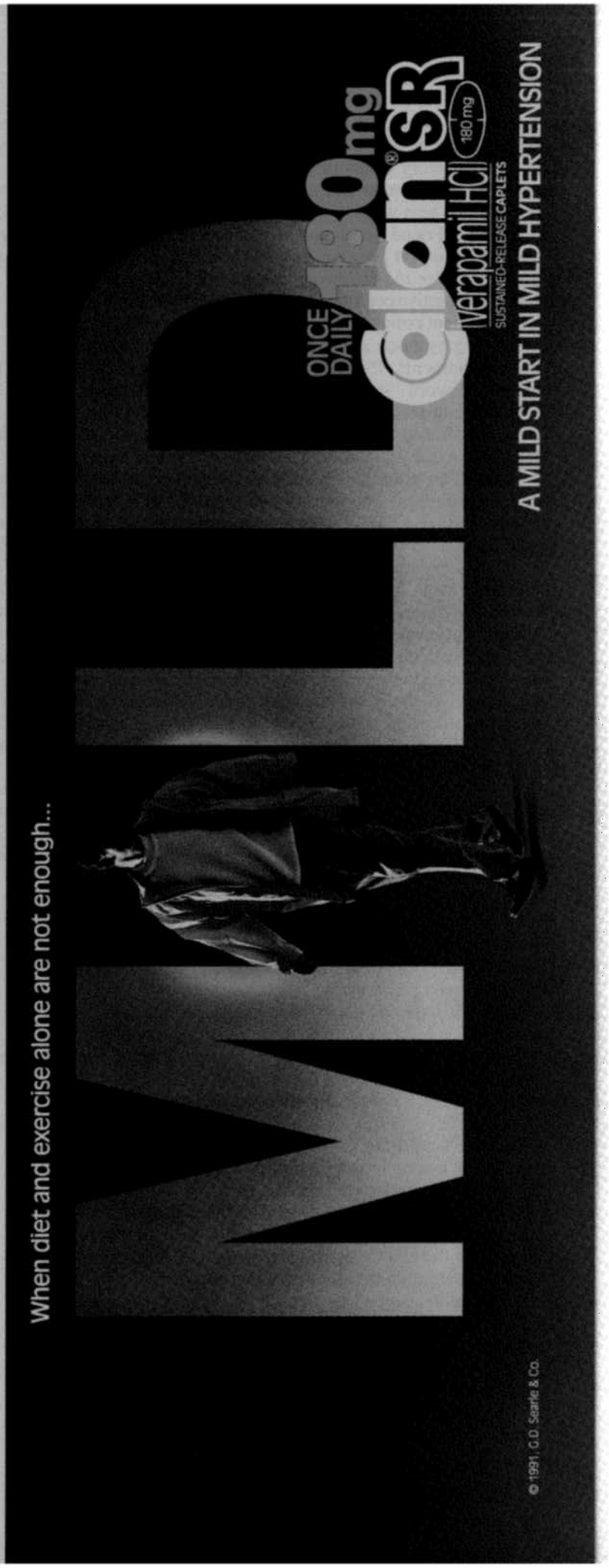


adjournment — to catch a plane and return home at a reasonable hour. The resultant "thinned" quorum does not make for good participatory democracy, nor a properly reasoned vote, especially on an important issue that is to determine HMA policy for the next year.

The Bade/Friend Resolution, in essence, recommended that *"the HMA support prescriptive powers for nurse practitioners, only under the following conditions,"* and there were some 10 restrictive conditions spelled out.

(The current policy of the HMA is a blanket NO.)

The lengthy discussion was fraught with attempts to propose amendments. Perhaps the most cogent ones were to change the word "support" to "oppose" and to change the accompanying modifiers from "under ..." to "unless the following conditions are met:" and the other was that both the Medical Practice Act and the Pharmacy Act would have to be amended. The polarization took place between those who favored an absolute "no prescriptive privilege to be given to anyone without an MD degree" to one that "would allow it under close supervision by a licensed MD." Spokespersons for the Hawaii Federation of Physicians and Dentists were the most adamant in favoring the former, whereas others backed the intent of the ad hoc committee as described below.

The unfortunate thing about the discussion and the vote to defeat the Resolution was that the HMA was labeled as being adamant about preserving the status quo. This does not reflect the fact that at the Reference Committee hearings, speakers were evenly divided, some 20 on each side, pro and con.

An HMA poll of its members taken much earlier and prior to debate had indicated, on the other hand, a 63% opposition; 37% — a bit more than a healthy third of our members — favored giving prescriptive rights to CNPs and to Certified Nurse Midwives, *but with restrictions.*

The HMA policy has been criticized for being "not in line with national policy, wherein 38 states do allow prescriptive privileges." However, that is <10% of the truth, because only 3 of the states allow such without MD supervision.

Since the physician is the one responsible, and liable, it should be up to him or her as to the limits of such supervision for the following reasons:

(1) This is already going on in the practice of medicine in many venues;

(2) the capabilities of RNs and other highly trained paramedics have increased tremendously during the past 50 years; however, they are still short of the qualifications of a physician;

(3) One would not expect such a paramedic to want to assume the awesome responsibility of a modern physician, who faces the worrisome prospect of doing more harm than good to the patient with powerful drugs and invasive techniques, and who has been saddled with a huge burden of liability under the law by our society in the case of even a mal-happenstance and in the absence of mal-practice;

(4) therefore, depending on each physician's willingness to assume the responsibility for an extender, depending on the competence and reliability of that extender, depending on the trust between physician and extender, prescriptive powers could be delegated to such extenders, be they registered nurses, trained assistants, optometrists, or psychologists (for starters), who are willing and able to assume responsibility and liability, in close conjunction with a physician who is equally willing to assume the burden of carrying someone besides himself;

(5) the ultimate consideration should be whether the patient would benefit rather than be harmed by such a system of medical practice and not whether it be a matter of whose ox is gored. We prefer the term collaboration with, instead of suprvision by, a physician.

J I Frederick Reppun MD
Editor

The patient's right to die

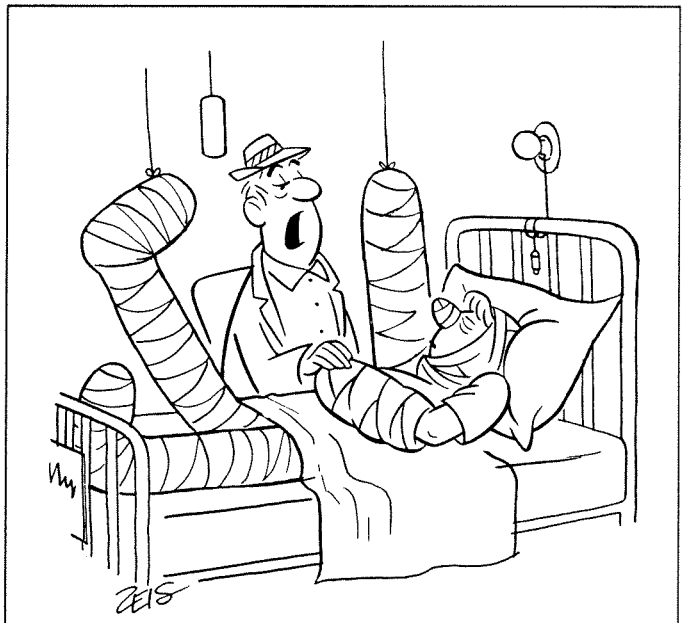
In this issue of the Journal we have an article emanating from our school of medicine. McDermott et al report on a survey of graduating medical students that assesses what the latter considered to be the most important ethical dilemma that these students faced during their clinical years at the school. It was, indeed, in large measure the doctor-patient-family confrontation with the patient's wish to be allowed to die.

It is interesting to note that the issue was addressed and the survey done several years prior to the Supreme Court's ultimate decision in the Cruzan case in June 1990. One can say that the current rise of this issue to the forefront of attention on the part of the lay community dates from not long before the 1990 Court decision.

However, our young *kahuna haumana lapa'au* had already experienced the dilemma which physicians down through the ages have had to face at the bedside of the dying patient.

The national debate on the dilemma has evolved to a new level: Rational suicide. Our readers might like to be referred to the October 10 issue of the *NEJM,* pp 1100-1102; the Sounding Board has a well thought-out treatise on the subject with a good list of references at the end.

J I Frederick Reppun MD
Editor



"Everybody hopes you'll remember next time dear ... ya never walk in front of a TV during a 95-yard punt return!"